

DEPARTMENT OF HEALTH AND HUMAN SERVICES
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495409	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 1 B. WING _____	(X3) DATE SURVEY COMPLETED 09/08/2015
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NAME OF PROVIDER OR SUPPLIER ABINGDON HEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 15051 HARMONY HILLS LANE ABINGDON, VA 24212
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Description of structure: One story Type V(111) exterior brick and vinyl veneer nursing home Sprinkler status: Fully sprinklered An unannounced routine Life Safety Code survey was conducted September 8, 2015 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2000 NEW regulations. The facility was not in compliance with the Requirements for Participation Medicare and Medicaid. The findings that follow demonstrate non-compliance with Title 42 Code of Regulations, 483.70(a) et seq (life Safety from Fire.)	K 000	All findings as identified non- compliance with Title 42 Code of Regulations, 483.70 (a) et seq (life Safety from Fire) have been corrected	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 This Standard is not met as evidenced by: Based on observation and interview, the delayed egress exit door in the rear hall by the staff lounge did not release with 15 seconds when pushed. The findings include: On September 8, 2015 at 1016 hours accompanied by the Maintenance Director, the delayed egress door in the rear hallway and next to the staff lounge did not release within 15 seconds when the panic hardware was pushed. The Maintenance Director agreed with the findings.	K 038	K038 Corrected. The delayed egress exit door in the rear hallway by staff lounge was repaired/adjusted on day of survey to release within 15 seconds when the panic hardware is pressed continuously. All other exit doors with delayed egress have been checked and found to work in accordance to Title 42 Regulations and release with 15 seconds when the panic hardware is pressed for 15 seconds.	9/30/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Stephen Keyno (B Administrator)</i>	TITLE <i>Administrator</i>	(X6) DATE <i>9-18-15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPrinted: 09/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495409	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 1 B. WING _____		(X3) DATE SURVEY COMPLETED 09/08/2015
NAME OF PROVIDER OR SUPPLIER ABINGDON HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 15051 HARMONY HILLS LANE ABINGDON, VA 24212		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 038 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the delayed egress exit door in the rear hall by the staff lounge did not release with 15 seconds when pushed.</p> <p>The findings include: On September 8, 2015 at 1016 hours accompanied by the Maintenance Director, the delayed egress door in the rear hallway and next to the staff lounge did not release within 15 seconds when the panic hardware was pushed. The Maintenance Director agreed with the findings.</p>	K 038	<p>All exit doors with delayed egress will be checked by facility Maintenance two times weekly for four weeks followed by monthly inspections for 9 additional months. Records will be maintained for audit inspections upon request.</p> <p>Facility Maintenance will present such records for review to the Quality Assurance Committee and Facility Safety Committee on a monthly basis for three months and then quarterly for one year to ensure compliance to 42 Code of Regulations and facility safety. The facility administrator ensure compliance to the regulations.</p>	9/30/15	

K 038 Continued from page one of one

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER ABINGDON HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 15051 HARMONY HILLS LANE ABINGDON, VA 24212		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 051 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the records for the annual testing of the fire alarm did not comply with NFPA 72 (7-5.2.2). 1999 edition.</p> <p>The findings include: On September 8, 2015 at 1130 hours accompanied by the Maintenance Director, A review of the fire alarm inspection report records found that the records did not include all of the items specified in 7-5.2.2 NFPA 72 1999 edition. The Maintenance Director agreed with the findings.</p>	K 051	<p>K 051 Corrected. Fire Alarm system is maintained in accordance with NFPA 72 National Fire Alarm Code, and records of such maintenance are available for review. Written records as specified in 7-5.2.2 NFPA have been obtained, are on site, and available as provided by the Contracted Vendor (Fire Life Safety America, Inc.).</p> <p>No other occurrences are identified to K051</p> <p>Education and requirements provided to contracted vendor (Fire Life Safety America) to provide all necessary records in accordance to NFPA including sections 7-5.2.2 upon routine inspections.</p> <p>Facility Administrator will ensure that vendor provides completed records as required. Records will be presented to facility safety committed for review and or directions as necessary and shall be filed with records for all routine fire safety inspections.</p>	9/30/15

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE
NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM
OR SNFs AND NFs

PROVIDER #

495409

DATE SURVEY
COMPLETE:
09/08/2015

NAME OF PROVIDER OR SUPPLIER

ABINGDON HEALTH CARE LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

15051 HARMONY HILLS LANE
ABINGDON, VA. 24212PREFIX
AG

SUMMARY STATEMENT OF DEFICIENCIES

K 130 NEPA 101 MISCELLANEOUS

OTHER LSC DEFICIENCY NOT ON 2786

This Standard is not met as evidenced by:

Based on observation and interview, there was an air conditioner obstructing the electrical panel in the electrical/data room.

The findings include: On September 8, 2015 at 1023 hours accompanied by the Maintenance Director, there was an air conditioner obstructing the electrical panel in the electrical/data room. The Maintenance Director agreed with the findings. The air conditioner was moved out of the room during the inspection.

K130 Corrected

The air conditioner was removed on day of survey. All other electrical/data rooms found clear of any items stored. Facility maintenance staff has been educated on not storing item(s) in electrical/data rooms. Facility safety committee members will monitor monthly for three months, followed by quarterly for 9 months to ensure no storage of such items and shall report findings to safety committee for review and/or direction by facility administrator. The facility administrator does assure compliance to K130. 9/30/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 14 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

The above isolated deficiencies pose no actual harm to the residents

FIRE SAFETY SURVEY REPORT 2000 CODE – HEALTH CARE

Medicare - Medicaid

1. (A) PROVIDER NUMBER
K1 4954091. (B) MEDICAID I.D. NO.
K2 495409PART I – Life & Safety Code, New and Existing
PART IV – Waiver Recommendation Form

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BUDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	A. <input checked="" type="checkbox"/> Fully Sprinklered (All required areas are sprinklered) B. <input type="checkbox"/> Partially Sprinklered (Not all required areas are sprinklered) C. <input type="checkbox"/> None (No sprinkler system) K0180
Abingdon Health Care LLC	K3	15051 Harmony Hills Lane Abingdon, Virginia 24211	

3. SURVEY FOR X MEDICARE X MEDICAID	4. DATE OF SURVEY September 8, 2015 K4	DATE OF PLAN APPROVAL February 3, 2011 K5	SURVEY UNDER 5. <input type="checkbox"/> 2000 EXISTING 6. <input checked="" type="checkbox"/> 2000 NEW K7

5. SURVEY FOR CERTIFICATION OF 1. <input type="checkbox"/> HOSPITAL 2. <input checked="" type="checkbox"/> SKILLED/NURSING FACILITY	4. <input type="checkbox"/> ICF/MR UNDER HEALTH CARE	5. <input type="checkbox"/> HOSPICE	3. <input type="checkbox"/> IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED BY JCAHO/AOA?

6. BED COMPOSITION a. TOTAL NO. OF BEDS IN THE FACILITY 120	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE 0	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE 120	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID 120	e. NUMBER OF NF or ICF/MR BEDS CERTIFIED FOR MEDICAID 0

7. A. ☒ THE FACILITY MEETS, BASED UPON (CHECK ALL APPROPRIATE BOXES)
1. COMPLIANCE WITH ALL PROVISIONS 2. ☒ ACCEPTANCE OF A PLAN OF CORRECTION 3. ☐ RECOMMENDED WAIVERS 4. ☐ FSES 5. ☐ PERFORMANCE BASED DESIGN
B. ☐ THE FACILITY DOES NOT MEET THE STANDARD

SURVEYOR (Signature) K10	TITLE	OFFICE	DATE
<i>[Signature]</i>	Asst. Fire Marshal	Virginia State Fire Marshal's Office Southwestern Regional Office Chilhowie, Virginia	9/9/2015
FIRE AUTHORITY OFFICIAL (Signature) <i>Clayton B. Hutton</i>	TITLE Fire Marshal Manager	OFFICE Virginia State Fire Marshal's Office Southwestern Regional Office Chilhowie, Virginia	DATE 9/21/2015

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-2042. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, Attn: PRA Reports Clearance Officer, 75000 Security Boulevard, Baltimore, Maryland 21244-1850.

**FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)**

PROVIDER NUMBER	FACILITY NAME Abingdon Health Care LLC	SURVEY DATE September 8, 2015 * K4
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DATE OF PLAN APPROVAL February 3, 2011	K3 MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS <u>01</u> NUMBER OF THIS BUILDING <u>01</u>	A A BUILDING B WING C FLOOR D APARTMENT UNIT
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FORM INDICATOR

Health Care Form		
12	2786R	2000 EXISTING
13	2786R	2000 NEW
ASC Form		
14	2786U	2000 EXISTING
15	2786U	2000 NEW
ICF/MR Form		
16	2786V, W, X	2000 EXISTING
17	2786V, W, X	2000 NEW

13 SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: ☐ 1 PROMPT
☐ 2 SLOW
☐ 3 IMPRACTICAL

LARGE

K8: ☐ 4 PROMPT
☐ 5 SLOW
☐ 6 IMPRACTICAL

APARTMENT HOUSE

K8: ☐ 7 PROMPT
☐ 8 SLOW
☐ 9 IMPRACTICAL

Check if K29 or K56 are marked as not applicable (e.g. 2786 M, R, T, U, V, W, X and Y.)

K29 ☐ K56: ☐

ENTER E - SCORE HERE

K29 ☐ e.g. 2.5

FACILITY MEETS LSC BASED ON (Check all that apply)

A1. ☐ (COMP. WITH ALL PROVISIONS)
 A2. ☒ (ACCEPTABLE POC)
 A3. ☐ (WAIVERS)
 A4. ☐ (FSES)
 A5. ☐ (PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. ☐

K0180

A. ☒ FULLY SPRINKLERED (All required areas are sprinklered)
 B. ☐ PARTIALLY SPRINKLERED (Not all required areas are sprinklered)
 C. ☐ NONE (No sprinkler system)

MANDATORY